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ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

ORIGINAL CERTIFICATE OF DEATH

State Index - - - No. 545
County Registrar's - No.
Local Registrar's - No.

PLACE OF DEATH

1. County **Yavapai**

District **Congress**

Town or City **Wickenburg**

No. _____ St., _____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street number)

2. FULL NAME **Charles Ruckelhausen**

(a) Residence. No. **Wickenburg Arizona:** St., _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS		
3. SEX	4. COLOR or RACE	5. SINGLE, MARRIED, WIDOWED or DIVORCED (Write the word)
M.	**White**	**Single**

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	IF LESS than 1 day....hrs. or.....min.
	75			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Miner**
(b) General nature of industry, business or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) **Germany**
(State or country)

10. NAME OF FATHER **Unknown**

11. BIRTHPLACE OF FATHER **Unknown**
(city or town)
(State or country)

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER **Unknown**
(city or town)
(State or country)

14. Informant **William White**
(Address)

15. Filed **3/12**, 19**26** _____ Local Registrar.

Filed _____, 19 _____ County Registrar.

V. S. No. 1

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) **Mch. 3** 19

17. I HEREBY CERTIFY, That I attended deceased from _____
_____, 19 ___ to _____, 19 ___,

that I last saw h___ alive on _____; 19 ___,

and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

By a gun shot wound inflicted by himself.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) _____ **Coroner**, M. D.

19 ___ (Address) **Congress Ariz**

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Near Wickenburg	19
20. UNDERTAKER **None**	ADDRESS